COVER PAGE

TABLE OF CONTENTS

Page

1. DEFINTIONS

1.1. **Action** in the context of PIHP services means

1.1.1. the denial or limited authorization of a requested service, including the type or level of service;

1.1.2. the reduction, suspension, or termination of a previously authorized service;

1.1.3. the denial in whole or in part, of payment for a service;

1.1.4. the failure to provide services in a timely manner, as defined by the state;

1.1.5. the failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b) or;

1.1.6. for a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under section 42 CFR 438.52 (b)(2)(ii), to obtain services outside the network.

1.2. **Administrative Cost** means costs for the general operation of the public mental health system. These activities can not be identified with a specific direct or direct services support function.

1.3. **Annual Revenue** means all revenue received by the Contractor pursuant to the Agreement for July of any year through June of the next year.

1.4. **Appeal** means a request for review of an action as "action" is defined above.

1.5. **Available Resources** means funds appropriated for the purpose of providing community MH programs, federal funds, except those provided according to Title XIX of the Social Security Act, and state funds appropriated under chapter (1290) or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other MH services. This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals, except as negotiated according to RCW 71.24.300(1) (d).

1.6. **Capitation Payment** means a payment the Department of Social and Health Services (DSHS) makes periodically to a PIHP on behalf of each recipient enrolled under a contract for the provision of medical services under the State Medicaid Plan. MHD makes the payment regardless of whether the particular recipient receives the services during the period covered by the payment.

1.7. **Central Contract Services ("CCS")** means the Department of Social and Health Services (DSHS) office of Central Contract Services.

1.8. **CFR** means the Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

1.9. **Children's Long Term Inpatient Programs ("CLIP")** means the state appointed authority for policy and clinical decision-making regarding admission to and discharge from state-funded beds in the Children's Long Term Inpatient Programs (Child Study and Treatment Center, Pearl Street Center, McGraw Center, Tamarack Center)

1.10. **Community Mental Health Agency ("CHMA")** means Community Mental Health Agency that are subcontracted by the RSN and licensed to provide mental health services covered under this Agreement.

1.11. **Community Support Services** means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week, prescreening determinations for mentally ill persons being considered for placement in nursing homes as required by federal law, screening for patients being considered for admission to residential services, diagnosis and treatment for acutely mentally ill and severely emotionally disturbed children discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under chapter 71.05 RCW, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by regional support networks.

1.12. **Consumer** means a person who has applied for, is eligible for or who has received mental health services. For a child, under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

1.13. **Contractor** means the Contractor, its employees, agents and subcontractors

1.14. **Cultural Competence** means a set of congruent behaviors, attitudes, and policies that come together in a system or agency and enable that system or agency to work effectively in cross-cultural situations. A culturally competent system of care acknowledges and incorporates at all levels the importance of language and culture, assessment of cross-cultural relations, knowledge and acceptance of dynamics of cultural differences, expansion of cultural knowledge and adaptation of services to meet culturally unique needs.

1.15. **Early Periodic Screening Diagnosis and Treatment ("EPSDT")** means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act as amended.

1.16. **Emergent Care** means services provided for a person, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to RCW 71.05.

1.17. **Emerging Best Practice or Promising Practice** means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

1.18. **Enrollee** means a Medicaid recipient who is currently enrolled in a PIHP.

1.19. **Evidence Based Practice** means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

1.20. **Fair Hearing** means a hearing before the Washington State Office of Administrative Hearings.

1.21. **Family** means those the consumer defines as family or those appointed/assigned (e.g. parents, foster parents, guardians, siblings, caregivers, and significant others).

1.22. **Grievance** means the overall system that includes processes for grievance and appeals handled at the RSN level and access to the State fair hearing process.

1.23. **Medicaid Funds** means funds provided by CMS Authority under the Title XIX program.

1.24. **Medical Necessity or Medically Necessary** means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all.

Additionally, the individual must be determined to have a mental illness covered by Washington State for public mental health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.

1.25. **Mental Health Care Provider ("MHCP")** means the individual with primary responsibility for implementing an individualized service plan for mental health rehabilitation services.

1.26. **Mental Health Division ("MHD")** means the Mental Health Division of the Washington State Department of Social and Health Services ("DSHS"). DSHS has designated the Mental Health Division as the state mental health authority to

administer the state and Medicaid funded mental health programs authorized by RCW chapters 71.05, 71.24, and 71.34.

1.27. **Mental Health Professional** means;

1.27.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;

1.27.2. A person with a masters degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;

1.27.3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

1.27.4. A person who had an approved waiver to perform the duties of a mental health profession that was requested by the regional support network and granted by the mental health division prior to July 1, 2001; or

1.27.5. A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

1.28. **Large Rural Area** means areas with population density less than 20 people per square mile.

1.29. **Operating Reserve** means funds designated from mental health revenue sources that are set aside into an operating reserve account by official action of the RSN/PIHP governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of mental health services.

1.30. **Quality Assurance** means a focus on compliance to minimum requirements (e.g. rules, regulations, and contract terms) as well as reasonably expected levels of performance, quality, and practice.

1.31. **Quality Improvement** means a focus on activities to improve performance above minimum standards/ reasonably expected levels of performance, quality, and practice.

1.32. **Quality Strategy** means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of an organization’s or system’s operations

1.33. **Revised Code of Washington ("RCW")** means the Revised Code of Washington. All references to RCW chapters or sections shall include any successor, amended, or replacement statute.

1.34. **Regional Support Network ("RSN")** means a county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region.

1.35. **Resilience** means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

1.36. **Risk Reserve** Funds designated from mental health revenue sources that are set aside into a risk reserve account by official action of the RSN's governing body. Risk reserve funds may only be set aside for use in the event costs of providing service exceed the revenue the RSN receives.

1.37. **Routine Care** means a setting where evaluation and mental health services are provided to consumers on a regular basis. These services are intended to stabilized, sustain, and facilitate consumer recovery within his or her living situation and they do not meet the definition of urgent or emergent care.

1.38. **Routine Services** means non-emergent and non-urgent services are offered within fourteen (14) calendar days to individuals authorized to receive services as defined in the access to care standards. Routine services are designed to alleviate symptoms, to stabilize, sustain and facilitate progress toward mental health.

1.39. **Rural Area** means areas with a population density of at least 20 and less than 500 people per square mile

1.40. **Service Areas** means the geographic area covered by this Agreement for which the Contractor is responsible.

1.41. **Severely Emotional Disturbed Child** means a child who has been determined by the regional support network to be experiencing a mental disorder as defined in chapter 71.34 RCW, including those mental disorders that result in a behavioral or conduct disorder, that is clearly interfering with the child's functioning in family or school or with peers and who meets at least one of the following criteria:
(a) Has undergone inpatient treatment or placement outside of the home related to a mental disorder within the last two years;
(b) Has undergone involuntary treatment under chapter 71.34 RCW within the last two years;
(c) Is currently served by at least one of the following child-serving systems: Juvenile justice, child-protective/welfare, special education, or developmental disabilities;
(d) Is at risk of escalating maladjustment due to:
(i) Chronic family dysfunction involving a mentally ill or inadequate caretaker;
(ii) Changes in custodial adults;

(iii) Going to, residing in, or returning from any placement outside of the home, for example, psychiatric hospital, short-term inpatient, residential treatment, group or foster home, or a correctional facility;
(iv) Subject to repeated physical abuse or neglect;
(v) Drug or alcohol abuse; or,
(vi) Homelessness.

1.42. **Subcontract** means a separate contract between the RSN and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations which the RSN is obligated to perform pursuant to this Agreement.

1.43. **Unobligated Mental Health Fund Balance** Funds designated from mental health revenue sources that have not been spent in the fiscal period they were received. These funds have not been set aside into a specific reserve account by official action of the RSN's governing body, but they may be identified by the RSN for a specific use.

1.44. **Urban Area** means areas that have a population density of at least 500 people square mile.

1.45. **Washington Administrative Code ("WAC")** means the Washington Administrative Code. All references to WAC chapters or sections shall include any successor, amended, or replacement regulation.

2. **POPULATIONS SERVED -** Within the resources provided under this agreement the Contractor shall provide access to**:**

2.1. **Crisis Mental Health Services** for all individuals within the contracted services area.

2.2. **Involuntary Psychiatric Inpatient Services** for individuals who are involuntarily detained in accordance with RCW 71.05 or 71.34, and who are either eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program that would cover this hospitalization.

2.3. **Voluntary Psychiatric Inpatient Services** for individuals who are beneficiaries of the following State-funded assistance programs: Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U) and reside within the contracted service area.

2.4. **State Hospital and CLIP Psychiatric Inpatient Services** for individuals who reside within the contracted service area.

2.5. **Medicaid Personal Care** for individuals who reside within the contracted service area and are Medicaid-Enrollees.

2.6. **Residential and Outpatient Mental Health Services** for individuals who reside within the contracted service area who are not eligible to receive these services

under a Medicaid entitlement program and who are members of priority populations (RCW 71.24).

3. INFORMATION REQUIREMENTS

3.1. **Information Requirements**: The Contractor shall ensure all individual information complies with WAC 388-865-0410. The Contractor shall maintain written policy and procedures addressing all information requirements, and shall,

3.1.1. Assure that interpreter services are provided for individuals with a primary language other than English for all interactions between the individual and the Contractor including, but not limited to, services, all appointments for any covered service, crisis services, and all steps necessary to file a grievance;

3.1.2. Provide all written information and post mental health rights in the following languages: Cambodian, Chinese, Korean, Laotian, Russian, Spanish and Vietnamese; and

3.1.3. Provide information that clearly explains to individuals how the individual can request and be provided written materials in alternate formats. Information explaining to the individual how to access these materials must be provided prior to an intake evaluation in an easily understood format.

3.1.4. Upon an individual's request, the Contractor shall provide:

3.1.4.1. Community Mental Health Agency (CMHA) licensure, certification and accreditation status; and

3.1.4.2. Information that includes but is not limited to, education, licensure, and Board certification or re-certification or registration of mental health professionals and MHCPs.

3.2. **Customer Services**

3.2.1. The Contractor shall provide Customer Services that are customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders.

3.2.2. Customer Services staff shall:

3.2.2.1. Answer consumer service lines via both local and toll free numbers to respond to inquiries and complaints from 8a.m. until 5:00 p.m. Monday through Friday, holidays excluded.

3.2.2.2. Answer calls within 5 rings, with an average speed of answer of 30 seconds, and a call abandonment rate of less than 3 percent.

3.2.2.3. Respond to inquiries or complaints and assist consumers, family members and stakeholders in a manner that resolves their inquiry,

including the ability to respond to those with limited English proficiency or the hearing impaired.

3.2.3. The Contractor shall train Customer Services staff to distinguish between a complaint, Third Party Insurance issue, or grievances and how to triage these to the appropriate party. Logs shall be kept that at a minimum track:

3.2.3.1. The date of initial call, type of call, and resolution date.

3.2.3.2. The volume of calls and call responsiveness statistics on the consumer service line.

3.2.3.3. The number of calls by category, average days to resolution, and percent of complaints resolved within 30 days.

3.2.4. Provide telephonic and written information as specified in the Information Requirements Section including materials provided by DSHS, at convenient times, in accessible locations.

4. PAYMENT

4.1. Contractor shall ensure that all funds, including interest earned, provided pursuant to this Agreement are used to support the public mental health system.

4.2. State funds will be paid in the amount of $ per month, not to exceed the maximum amount of $ for this Agreement's period of performance. Payments are entered into the accounting payment system the first working day of the month.

4.2.1. Estimated Non-Medicaid Utilization: This estimate is calculated twice per year, in January and in July. From the period of time 12-18 months prior to the date of calculation (based on the first date of service), MHD calculates the monthly averages of the actual non-Medicaid hospital utilization.

4.2.2. The Initial Estimate payment is calculated as the Estimated Gross Payment less Estimated Non-Medicaid Utilization.

4.2.3. 18-Month Reconciliation: The 18-Month Reconciliation payment is an adjustment for community hospital utilization for a particular month of service. The process for measuring community hospital utilization to be charged to the RSNs is complete eighteen (18) months after a particular month of service. The 18-Month Reconciliation is calculated as the Estimated Non- Medicaid Utilization less the Actual Non- Medicaid Utilization. MHD returns the difference for any decrease in usage ~~(~~above the initial estimate for a particular month of service~~)~~ and collects for any increase over the initial estimate. Reconciliation ends 18 months after the end of the last month of the contract term.

4.2.4. Each payment will be reduced by the amount paid by MHD on behalf of the Contractor for unpaid assessments, penalties, and other payments pending a dispute resolution process. If the dispute is still pending June 1, 2007, MHD will withhold the amount in question from the final payment until the dispute is resolved.

4.2.5. If the Contractor terminates this Agreement or will not be entering into any subsequent agreements, the MHD will require the spend-down of all remaining reserves and fund balances within a reasonable timeframe developed with MHD. Funds will be deducted from the final months' payments until reserves and fund balances are spent. Any funds not spent for the provision of services under this contract shall be returned to MHD within 60 days of the last day the contract is in effect.

4.2.6. MHD will withhold 50 percent of the final payment under this Contract until all final reports and data are received and accepted by DSHS, and until all pending corrective actions, penalties, or unpaid assessments are satisfied.

4.3. Additional State funds will be paid in the amount of $ per month not to exceed $ solely for the provision of Jail Coordination Services. This funding shall supplement, and not supplant, local or other funding or in-kind resources.

4.4. The Contractor may have an additional Operating Reserve, not to exceed 5% of the Contractor's annual non-Medicaid payments.

5. REPORTING AND DELIVERABLES

5.1. The Contractor must ensure plans or reports required by this Agreement are provided to DSHS in compliance with the timelines and/or formats indicated. The RSN Administrator or designee will attest, based on best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of documents submitted to MHD.

5.2. The Contractor shall submit membership rosters of the advisory board showing compliance with WAC 388-865-0222 to the MHD within 60 days of the execution of this contract. Any change in membership must be reported within 30 days of the change

5.3. The Contractor must establish a governing body responsible for oversight of the Regional Support Network. The governing body must be free from conflicts of interest and from any appearance of conflicts of interest between personal, professional and fiduciary interests of a governing body member and best interests of the RSN and the consumers it serves. The Contractor must submit membership roster(s) and by-laws of the governing body demonstrating compliance. These must be submitted to MHD for review 60 days after execution of this agreement. The Governing body by-laws must include:

5.3.1. Actions to be taken when a conflict of interest, or the appearance of a conflict of interest, becomes evident;

5.3.2. Requirements that members refrain from voting or joining a discussion when a conflict of interest is present; and

5.3.3. A process for the Governing Body to assign the matter to others, such as staff or advisory bodies to avoid a conflict of interest.

5.4. The Contractor shall submit to the MHD for approval its Level of Care Guidelines that meet the requirements described in the Resource Management Section within 90 days of the execution of this Agreement. The Contractor's Guidelines must be submitted to the MHD for approval 60 days prior to implementation of any changes.

5.5. If the Contractor provides or purchases 24-hour supervised crisis respite or hospital diversion beds, the Contractor must report these in a format provided by the MHD. This report must be submitted to the MHD 60 days after the execution of this Agreement.

5.5.1. The Contractor must report in a format provided by the MHD a description of the Residential Resources in the contracted service area. This report must be submitted to the MHD 60 days after the execution of this Agreement.

5.5.1.1. If the Contractor does not have capacity in a program identified in the Residential Programs section the report must include a Memorandum of Understanding or a contract to purchase the program outside of the contracted service area.

5.6. **Financial Reporting and Certification:** The following reports and certifications, in formats provided by MHD, must be submitted on a quarterly basis. Reports are due within 30 days of the quarter end (September, December, March, and June of each year). The MHD reserves the right to require more frequent submission of the Revenue and Expenditure reports:

5.6.1. Revenue, expenditure, and fund balance report in compliance with the provisions in the BARS Supplemental Instructions for Mental Health Services promulgated by the Washington State Auditor's Office.

5.6.2. The amounts paid to FQHCs for services must be reported and submitted as separate additional information to the revenue and expenditures reports. The report must include third party revenue collected by subcontractors, including revenue received from Medicare, insurance company, and co-payment.

5.6.2.1. The Contractor must certify that administrative costs incurred by the Contractor are no more than 10 percent of the annual revenue supporting the public mental health system operated by the Contractor. Administration costs shall be measured on a fiscal year basis and based

on the information reported in the Revenue and Expenditure reports and reviewed by MHD.

5.6.2.2. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources are identified, pursued, and recorded by the subcontractor.

5.6.3. If the Contractor is unable to certify the validity of the certifications or if DSHS finds discrepancies in the Revenue and Expenditure Report, DSHS may initiate remedial action. Remedial action may include recoupment from funds disbursed during the current or successive Agreement period. Recoupment shall occur within 90 days of the close of the State fiscal year or within 90 days of the MHD's receipt of the certification, whichever is later.

5.6.4. The Contractor shall report the level of PIHP operating reserve accounts and unobligated mental health fund balances to MHD according to the BARS Supplemental Instructions issued by the State Auditor

5.6.5. MHD reserves the right to modify the form, content, instruction, and timetables for collection and reporting of financial data. MHD agrees to involve the RSN in the decision process prior to implementing changes in format, and shall request the RSN to review and comment on format changes before they go into effect.

6. QUALITY OF CARE

6.1. The Contractor shall participate with DSHS in the implementation, update and evaluation of the Quality Strategy, located on the DSHS website.

6.2. The Contractor shall use its collected data, monitoring results, and services verification to review its ongoing quality management program. The Contractor shall engage in ongoing assessment and improvement of the quality of public mental health services in its service area, as well as evaluate the effectiveness of the overall regional system of care. At a minimum the Contractor shall:

6.2.1. Assess the degree to which mental health services and planning is driven by and incorporates individual and family voice;

6.2.2. Assess the degree to which mental health services are age, culturally and linguistically competent;

6.2.3. Assess the degree to which mental health services are provided in the least restrictive environment;

6.2.4. Assess the degree to which provided mental health services assist individuals' progress toward recovery and resiliency; and,

6.2.5. Assess the continuity in service and integration with other formal/informal systems and settings;

6.3. The Contractor shall ensure relevant results of grievances, fair hearings, reported sentinel incidents, are incorporated into system improvement.

6.4. The Contractor shall provide the interpretation of quality improvement feedback to CMHAs, the advisory board, and other interested parties.

6.5. The Contractor shall ensure that a group of individuals and individuals' families representative of the community being served, including all age groups, are invited to participate in planning activities and in the implementation and evaluation of the public mental health system. The Contractor must be able to demonstrate how this requirement is implemented

6.6. The Contractor shall participate with MHD in the development and implementation of a standard set of performance indicators to measure access, quality and appropriateness. Participation must include:

6.6.1. Provision of all necessary data;

6.6.2. The analysis of results and development of system improvements based on that analysis on a local and statewide basis; and

6.6.3. Incorporation of the results into quality improvement activities.

6.7. The Contractor shall participate with MHD in completing annual Mental Health Statistics Improvement Project (MHSIP) survey for youth and families. Participation must include at a minimum:

6.7.1. Provision of individual contact information to MHD;

6.7.2. Involvement in the analysis of results and development of system improvements based on that analysis on a statewide basis; and

6.7.3. Incorporation of results into RSN specific quality improvement activities.

6.8. The Contractor shall attempt to initiate and complete a TeleSage outcome survey on every individual.

6.9. **Quality Review Activities**

6.9.1. The Department of Social and Health Services (DSHS), Office of the State Auditor, or any of their duly-authorized representatives, may conduct announced and unannounced:

6.9.1.1. Surveys, audits and reviews of compliance with licensing and certification requirements and the terms of this Agreement;

6.9.1.2. Audits regarding the quality, appropriateness, and timeliness of mental health services provided under this contract; and

6.9.1.3. Audits and inspections of financial records.

6.9.2. The Contractor shall notify MHD when an entity other than DSHS performs any audit described above related to any activity contained in this Agreement.

6.9.3. **Sentinel Event Reporting**: The Contractor shall notify MHD of any sentinel incident as described below:

6.9.3.1. Examples of incidents to report include but are not limited to: homicide, attempted homicide, completed suicide, the unexpected death of a consumer, abuse or neglect of an individual receiving mental health services by an employee or volunteer, loss of crisis lines, and loss of service or residential sites.

6.9.3.2. Notification must be made to the Mental Health Services Chief or his/her designee during the business day in which the Contractor becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next business day.

6.9.3.3. Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

6.9.3.4. When requested by MHD, a written report will be submitted within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

7. SUBCONTRACTS

7.1. Delegation

7.1.1. The Contractor must oversee, be accountable for, and monitor functions and responsibilities performed by or delegated to a subcontractor on an ongoing basis including the completion of an annual formal review.

7.1.2. Prior to any delegation of responsibility or authority to a subcontractor, the Contractor shall use a formal delegation plan, to evaluate the subcontractor's ability to perform delegated activities. The Contractor shall submit its delegation plan to the MHD for approval within 90 days of execution of this Agreement. The delegation plan must include the following:

7.1.2.1. An evaluation of the prospective subcontractor's ability to perform delegated activities;

7.1.2.2. A detailed description of the proposed subcontracting arrangements, including (1) name, address, and telephone number of the sub-contractor(s), (2) specific contracted services, (3) compensation arrangement, and (4) monitoring plan;

7.1.2.3. A copy of the existing or draft subcontract that specifies the activities and report responsibilities delegated and provides for revoking delegation or

imposing other sanctions if the subcontractor's performance is not adequate; and

7.1.2.4. The Care Management functions as described in this contract cannot be delegated to a subcontracted CMHA within the Contractor's service area.

7.1.3. No delegation or subcontract will terminate the legal responsibility of the Contractor to perform the terms of this Agreement. The Contractor is fully responsible for all services provided under the terms of this Agreement, whether those services are rendered by subcontractors or non-contracted providers, and shall indemnify and hold harmless DSHS from any claims related to the provision of these services.

7.2. **Required Provisions**

7.2.1. The Contractor shall ensure that all subcontracts are in writing and specify all duties, reports, and responsibilities delegated under this Agreement. The Contractor shall submit copies of subcontracts to perform any function under this agreement to MHD within 30 days of execution of a subcontract or amendment of a subcontract. When possible, the copies are to be provided in word processing format in compact disc format.

7.2.2. Subcontracts must require subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the services to be performed under this Agreement.

7.2.3. Subcontracts must require subcontractors to cooperate with Quality Review Activities and provide access to their facilities, personnel and records.

7.2.4. Subcontracts must require subcontractors to participate in MHD-offered training on the implementation of Evidence Based Practices and Promising Practices.

7.2.5. Subcontracts must require subcontractors to provide individuals access to translated information and interpreter services as described in the Information Requirements section.

7.2.6. Subcontracts must require subcontractors to notify the Contractor in the event of a change of status of any required license or certification.

7.2.7. Subcontracts must require subcontractors to participate in training when requested by MHD.

7.2.8. Subcontracts must require compliance with State and federal non-discrimination policies, Health Insurance Portability and Accountability Act (HIPAA), and the MHD-CIS Data Dictionary.

7.2.9. Subcontracts must define a clear process to be used to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract.

7.2.10. Subcontracts must require that the subcontractor correct any areas of deficiencies in the subcontractor's performance that are identified by the Contractor or the Mental Health Division as part of a subcontractor review.

7.2.11. Subcontracts must require best efforts to provide written or oral notification within 15 working days of termination of a MHCP to individuals currently open for services who had received a service from the affected MHCP in the previous 60 days. Notification must be verifiable in the client medical record at the CMHA.

7.2.12. Subcontracts must require that the subcontracted CMHAs comply with the Contractor's policies and procedures for utilization of Access to Care Standards, and Access Standards.

7.2.13. Subcontracts must require that the subcontractor implement a Grievance process that complies with the Grievance section.

7.2.14. Subcontracts must require the pursuit of all Third Party Revenue.

7.3. **Termination:** The termination of a subcontract that provides mental health services is considered a significant change in the provider network. The Contractor must notify MHD 30 days in advance of public written notice to individuals before terminating any of its subcontracts with entities that provide direct service.

7.3.1. The Contractor must provide written notification within 15 days to individuals receiving services from the subcontractor upon written notification of termination by either party.

7.3.2. If either party must terminate a subcontract in less than 30 days, the Contractor must notify MHD as soon as there is a determination to terminate the subcontract and in advance of public notice.

7.3.3. If a CMHA contract is terminated, the Contractor must submit a transition plan for individuals and services in a format requested by MHD.

7.4. **Annual Review:** An annual formal review of subcontractors who perform the following activities must be performed by the Contractor. This review may be combined with a formal review of services performed pursuant to the Pre-Paid Inpatient Heath Plan Agreement between the Contractor and MHD. The review must be based on the requirements set forth in this contract, and the applicable statutes and regulations. The formal review must include at a minimum:

7.4.1. Quality clinical care;

7.4.2. Timely access;

7.4.3. Liability for Payment and the pursuit of third party revenue;

7.4.4. Quality Assessment and;

7.4.5. Intake Evaluations and Individual Service Plans.

7.5. **Provider Credentialing**

7.5.1. The Contractor shall have written policies that require monitoring of provider credentials. The Contractor shall only use CMHAs who are licensed or certified by the State.

8. INDIVIDUAL RIGHTS AND PROTECTIONS

8.1. The Contractor shall comply with any applicable Federal and State laws that pertain to individual rights and ensure that its staff takes those rights into account when furnishing services to individuals.

8.2. The Contractor shall ensure mental health professionals and MHCPs, acting within the lawful scope of mental health practice, are not prohibited or restricted from advising or advocating on behalf of an individual with respect to:

8.2.1. The individual's mental health status;

8.2.2. Receiving all information regarding mental health treatment options including any alternative or self administered treatment, in a culturally-competent manner;

8.2.3. Any information the individual needs in order to decide among all relevant mental health treatment options;

8.2.4. The risks, benefits, and consequences of mental health treatment (including the option of no mental health treatment);

8.2.5. The individual's right to participate in decisions regarding his or her mental health care, including the right to refuse mental health treatment and to express preferences about future treatment decisions;

8.2.6. The individual's right to be treated with respect and with due consideration for his or her dignity and privacy;

8.2.7. The individual's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

8.2.8. The individual's right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164;

8.2.9. The individual's right to be free to exercise his or her rights and to ensure that to do so does not adversely affect the way the RSN, CMHA or MHCP treats the individual;

8.2.10. Ensure that mental health professionals and MHCPs have an effective method of communication with individuals who have sensory impairments, and limited English proficiency; and

8.2.11. Provide or purchase age, linguistic and culturally competent community mental health services for individuals for whom services are medically necessary and clinically appropriate.

8.3. Individual service plans must be developed in compliance with WAC 388-865-0425.

8.3.1. The Contractor shall ensure individuals participate in the development of their individualized service plans, advance directives and crisis plans. This shall include but not be limited to children and their families (e.g. caregivers and significant others, parents, foster parents, assigned/appointed guardians, siblings). At a minimum, treatment goals must include the words of the individual receiving services and documentation must be included in the clinical record describing how the individual receiving services sees his/her progress.

8.3.2. An individual peer support plan may be incorporated in the individual service plan.

8.4. **Ombuds**

8.4.1. The Contractor shall provide a mental health ombuds as described in WAC 388-865-0250 and RCW 71.24 as amended by Laws of 2005, ch. 504 (E2SSB 5763). The mental health ombuds cannot be employed or otherwise controlled by the Contractor~~. or any entity affiliated with the Contractor.~~

8.5. **Advance Directives**

8.5.1. The Contractor shall maintain a written Advance Directive policy and procedure that respects individuals' Advance Directives for psychiatric care. Policy and procedures must comply with RCW 71.32. If State law changes, MHD will send notice to the Contractor who must then ensure the provision of notice to individuals within 90 days of the change.

8.5.2. The Contractor shall inform individuals that complaints concerning noncompliance with the Advance Directive for psychiatric care requirements may be filed with MHD by contacting the Quality Improvement and Assurance section at 1-888-713-6010.

9. **CARE MANAGEMENT PROGRAM –** Care management pertains to a set of clinical management oversight functions that shall be performed by the Contractor. <u>Care Management functions shall not be delegated to a network CMHA.</u> Care management focuses on access, referrals, oversight of care coordination, utilization review, resource

management, risk management, and quality improvement. These activities must be performed by a Mental Health Professional.

9.1. **Utilization Management Program**

9.1.1. The Contractor shall have a psychiatric medical director (consultant or staff) and sufficient care managers to carry out essential care management functions including:

9.1.1.1. A process for individuals to access an intake evaluation and a process for referral to crisis intervention services;

9.1.1.2. A utilization review of requested services against medical necessity criteria, and authorization of necessary care;

9.1.1.3. A review of assessment and treatment services against clinical practice standards. Clinical practice standards include but are not limited to evidenced-based practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals and other consumer serving agencies;

9.1.1.4. A monitoring process for over-utilization and under-utilization of services. The Contractor shall ensure that resource management and utilization management activities are not structured in such a way as to provide incentives for any individual or entity to deny, limit, or discontinue medically necessary mental health services to any individual; and

9.1.1.5. Maintenance of written policies and procedures for determining what constitutes medically necessary mental health services within the Contractor's service area. The policies and procedures must demonstrate:

9.1.1.5.1. Consistent application of review criteria for authorization decisions;

9.1.1.5.2. Consistent application of medical necessity criteria and the Access to Care Standards; and

9.1.1.5.3. Consultation with providers, when appropriate.

9.1.2. The Contractor shall participate as requested by MHD in the statewide analysis being conducted by the Performance Data Group of outpatient and inpatient hospital utilization rates for individuals who are African American and Native American. The analysis will include, but is not limited to factors that contribute directly and indirectly to utilization rates of these populations.

9.2. **Resource Management Plan**

9.2.1. The Contractor shall have eligibility criteria for initial authorization of outpatient mental health services and residential programs. The criteria may be more restrictive than the Access to Care Standards.

9.2.2. In addition to the Access to Care Standards, the Contractor's Level of Care Guidelines must also include: criteria for use in determining continued care or re-authorization following the exhaustion of previously authorized services by the individual, and must include criteria for use in determining when an individual shall be discharged from outpatient community mental health services.

9.2.3. Review criteria for use in determining continued or re-authorization following the exhaustion of previously authorized services by the individual. The review criteria must include:

9.2.3.1. An evaluation of the progress achieved and the effectiveness of each service modality provided;

9.2.3.2. An evaluation of the progress the individual made towards recovery or resiliency;

9.2.3.3. An identification of unmet needs including those identified by the individual; and

9.2.3.4. A method for determining if an individual has met discharge criteria.

9.2.4. The Contractor shall maintain written policy and procedures, and be able to demonstrate upon request, the consistent application of the Level of Care Guidelines within the Contractor's service area.

9.2.5. The contract shall have a protocol for verifying that authorized outpatient mental health services are consistent with the individual service plan.

9.2.6. The Contractor shall review the Individual Service Plan to ensure that:

9.2.6.1. The individual identified needs are being met;

9.2.6.2. The individual's participation in the service planning;

9.2.6.3. Involvement of family members as defined in this document, when appropriate, in the assessment and services planning processes; and

9.2.6.4. Input from other health, education, social service, and justice agencies, as appropriate and consistent with privacy requirements.

9.2.7. The Contractor must have Care Managers available 24 hours a day, 7 days a week to respond to requests for certification of psychiatric inpatient care in community hospitals. A decision regarding certification of psychiatric inpatient care must be made within twelve hours of the initial request.

9.2.7.1. Denials for certification of a psychiatric inpatient stay must be reviewed by a psychiatrist within 3 days of the initial denial.

9.2.8. If the Contractor denies payment to the inpatient facility for any portion of a psychiatric inpatient stay and the inpatient facility appeals, a response to the appeal must occur within 14 calendar days. The inpatient facility may appeal the Contractor's decision(s) to MHD after all reasonable efforts are made to resolve the dispute between the Contractor and the inpatient facility.

9.2.9. The Contractor must adhere to the requirements set forth in the Community Hospitalization Authorization Procedures (CHAP) available on the MHD Intranet or upon request.

9.2.10. Community psychiatric inpatient services are continued through the individual's discharge should a community hospital become insolvent, including any requirement for transfer.

10. MANAGEMENT INFORMATION SYSTEM

10.1. Data Submission and Error Correction

10.1.1. The Contractor shall provide the MHD all data described in the data dictionary for the Mental Health Division Consumer Information System (MHD-CIS), or any successor, incorporated herein by reference.

10.1.2. The Contractor shall submit encounters within 60 days of the close of each calendar month in which the encounters occurred.

10.1.3. The Contractor shall submit all other required data about individuals receiving services to the MHD within 60 days of collection or receipt from subcontracted providers.

10.1.4. Upon receipt of data submitted to the MHD, the MHD will generate an error report. The Contractor shall have in place documented policies and procedures that assure that data submitted and rejected due to errors are corrected and resubmitted within 30 calendar days of when the MHD error report was produced. All transactions will be final 180 days after the close of the submission month.

10.1.5. The Contractor shall have in place documented requirements to assure that data submitted by subcontractors and rejected due to errors is corrected and resubmitted within 30 calendar days of when the error report was produced.

10.1.6. The Contractor shall attend meetings and respond to inquires to assist in MHD decisions about changes to data collection and information systems to meet the terms of this contract. This may include requests to add, delete or change data elements that may include projected cost analysis.

10.1.7. The Contractor shall implement changes made to the MHD data dictionary within 120 days from the date of published changes.

10.1.8. The Contractor shall ensure that, for requested information not covered by the data dictionary, data is provided in a timeframe developed with the MHD at the time of the request that will allow for a timely response to inquiries from the legislature, the MHD, and other parties.

10.1.9. The Contractor shall be liable for any costs associated with additional data processing once transactions are final. Except when corrections are requested in writing by the MHD director, an office chief or their designee, the Contractor will not be held liable for cost associated with making the changes.

10.2. **Business Continuity and Disaster Recovery**

10.2.1. The Contractor shall demonstrate a primary and backup system for electronic submission of data requested by the MHD. This must include the use of the Inter-Governmental Network (IGN), ISSD-approved secured Virtual Private Network (VPN) or other ISSD-approved dial-up. In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on MHD approval. Documentation of the system to be used and its capabilities must be submitted to the MHD for approval within 60 days of the execution of this agreement.

10.2.2. The Contractor shall provide a business continuity and disaster recovery plan that insures timely reinstitution of the consumer information system following total loss of the primary system or a substantial loss of functionality. The plan must be submitted to the MHD for approval within 60 days of the execution of this agreement.

10.2.3. The Contractor will require all subcontractors to provide a business continuity and disaster recovery plan that insures timely reinstitution of the subcontractor's consumer information system following total loss of the primary system or a substantial loss of functionality. Subcontractor plans shall be provided to the MHD for approval within 60 days of the execution of the subcontract.

10.3. **Information System Security and Protection of Confidential Information**

10.3.1. The Contractor shall comply with applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified in 42 USC §1320(d) et.seq. and 45 CFR parts 160, 162 and 164.

10.3.2. The Contractor shall maintain a statement on file for each individual service provider and contractor staff who has access to the Contractor's mental health information system that is signed by the provider and attested to by a witness's signature, acknowledging that the provider understands and agrees to follow all regulations on confidentiality. (WAC 388-865-0275)

10.3.3. The Contractor shall take appropriate action if a subcontractor or Contractor employee willfully releases confidential information. (WAC 388-865-0275).

10.4. **Subcontractor Data Quality Verification**

10.4.1. The Contractor shall maintain and either provide to subcontractors, or require subcontractors to also maintain, a health information system that provides the information necessary to meet the subcontractor's obligations under this Agreement.

10.4.2. The Contractor shall have in place mechanisms to verify the health information received from subcontractors is accurate and complete. Mechanisms shall include the following:

10.4.2.1. Verifying the accuracy and timeliness of reported data; and

10.4.2.2. Screening the data for completeness, logic and consistency of the data received from subcontractors.

10.4.3. For all subcontractors that submit encounters to the Contractor, the Contractor shall conduct encounter validation checks using the following method:

10.4.3.1. Review the lesser of either 1% of all encounters or 250 encounters during the first 6 months of the Agreement period;

10.4.3.2. Compare the clinical record against the subcontractor's encounter data to determine agreement in type of service, date of service and service provider. This review must verify that the service reported actually occurred; and

10.4.3.3. Develop a report based on this information to be used in the Contractor's data monitoring activities. The report shall be submitted to MHD 30 days prior to the end of this Agreement.

10.5. **Data Certification**

10.5.1. The Contractor shall provide certification of encounter data by one of the following: Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer. The certification will attest, based on best knowledge, information, and belief, to the accuracy, completeness, and truthfulness of data. Batches that contain data errors will not be considered certified until corrections for all errors are successfully received by the MHD.

10.5.2. The Contractor shall use only the MHD-supplied certification form.

10.5.3. The Contractor shall submit an electronic copy (e-mail is sufficient) of each certification on same the day that the certified data is submitted. Send the original signed certification to the MHD Information Services Manager by mail as soon as possible.

10.5.4. The Contractor shall ensure that each certification contains an original signature of the signing authority.

10.5.5. If the signing authority is other than the CEO or CFO, the Contractor shall ensure that, a letter is submitted to the MHD containing an original signature by the CEO or CFO that indicates the name(s) of people delegated to sign. MHD must be notified by similar letter when delegation changes.

11. GRIEVANCE SYSTEM

11.1. General Requirements

11.1.1. The Contractor shall have in place a system for an individual that includes a grievance process, and access to the Fair Hearing system.

11.1.2. The Contractor's grievance system shall be consistently used throughout the Contractor's entire service area.

11.1.3. An individual may file a grievance or may have a representative who acts on his or her behalf in filing and pursuing grievances and administrative hearings.

11.2. Procedures

11.2.1. The individual or representative may file a grievance either orally or in writing.

11.2.2. A written, signed request for grievance must be submitted within 10 days if an initial request for such has been made orally.

11.3. **Handling of Grievances**

11.3.1. General requirements: In handling grievances, each RSN or agent must meet the following requirements:

11.3.1.1. Give individuals any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, provision of Ombuds services, interpreter services and toll-free numbers with adequate TTY/TTD capability;

11.3.1.2. Acknowledge receipt of each grievance received either orally or in writing within one working day. If acknowledgement is made orally, it must be followed-up in writing within five working days;

11.3.1.3. Ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making; and

11.3.1.4. Ensure that no retaliation is taken against individuals who file a grievance.

11.4. **Resolution and Notification:** Individuals who file a grievance shall be notified:

11.4.1. of their right to request a Fair Hearing, and how to do so;

11.4.2. of their right to request to receive medically necessary services while the hearing is pending;

11.4.3. how to make the request; and

11.4.4. that an individual may be asked to pay for the cost of those services if the hearing decision upholds the original decision.

11.5. **Continuation of Services**

11.5.1. The RSN must continue the individual's Medically Necessary services within available resources if:

11.5.1.1. The grievance involves the termination, suspension, or reduction of a previously authorized course of treatment;

11.5.1.2. The services were ordered by an authorized Community Mental Health Agency;

11.5.1.3. The original period covered by the original authorization has not expired; and

11.5.1.4. The individual requests extension of services.

11.6. **Information to RSNs and Sub-contractors**

11.6.1. The RSN must provide information about the grievance system to all Community Mental Health Agencies and sub-contractors at the time they enter into a contract. A condition of the contract will be that all Community Mental Health Agencies and sub-contractors will abide by all grievances and administrative hearing decisions.

11.7. **Record-keeping and Reporting Requirements**

11.7.1. PIHPs must maintain records of grievances and administrative fair hearings and must review the information per the timelines listed below.

11.7.2. The Contractor must submit a report in a format provided by MHD that includes:

11.7.2.1. The number and nature of, administrative fair hearings and grievances;

11.7.2.2. The timeframes within which they were disposed of or resolved;

11.7.2.3. The nature of the decisions; and

11.7.2.4. A summary and analysis of the implications of the data, including what measures may be taken to address undesirable patterns.

11.7.2.5. The report periods are October to March and April to September. In the event that the contract term does not encompass a full report period the Contractor shall provide a report for the partial period. Reports are due 45 days following the end of a report period.

12. **SERVICES**

12.1. **Required Services**. The Contractor is required to provide all of the following services as described in the Crisis Mental Health, Medicaid Personal Care and Inpatient sections, unless otherwise specified in this Agreement. These services must be prioritized for the use of funds provided in this Agreement.

12.1.1. **Crisis Mental Health Services**: The Contractor must provide 24-hour, 7 day a week crisis mental health services to individuals who are within the Contractor's service area and report they are experiencing a mental health crisis. There must be sufficient staff available, including Designated Mental Health Professionals, to respond to requests for crisis services. Crisis services must be provided regardless of the individual's ability to pay. Crisis mental health services must include each of the following:

12.1.1.1. Crisis Services: Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, the outcome of which decides whether possible bad consequences will follow. Crisis services

must be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services must be provided by or under the supervision of a mental health professional.

12.1.1.2. Stabilization Services: Services provided to individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services. This service may include cost for room and board.

12.1.1.3. Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 and RCW 71.34. This includes all clinical services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional determines an individual must be evaluated for involuntary treatment. ITA services continue until the end of the involuntary commitment.

12.1.1.4. Ancillary Crisis Services: Includes costs associated with providing medically necessary crisis services not included in the Medicaid State Plan. Costs include but are not limited to the cost of room and board in hospital diversion settings or in freestanding Evaluation and Treatment facilities.

12.1.1.5. Freestanding Evaluation and Treatment Services provided in freestanding inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may

include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

12.1.2. Crisis mental health services may be provided without an intake evaluation or screening process. The Contractor must provide:

12.1.2.1. Emergent care within 2-hours of the request received from any source for crisis mental health services.

12.1.2.2. Urgent care within 24-hours of the request received from any source for crisis mental health services.

12.1.3. The Contractor must provide access to all components of the Involuntary Treatment Act to persons who have mental disorders in accordance with State law (RCW 71.05 and RCW 71.34) and without regard to ability to pay.

12.1.4. The Contractor must incorporate the statewide protocols for County Designated Mental Health Professionals (CDMHP) or its successor into the practice of Designated Mental Health Professionals. The CDMHP protocols are incorporated by reference.

12.2. **Psychiatric Inpatient Services: Community Hospitals and Evaluation and Treatment Facilities**: The Contractor shall:

12.2.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300 (1) (d).

12.2.2. Provide or purchase psychiatric inpatient services when it is determined to be medically necessary for the following:

12.2.2.1. Individuals who agree to be admitted voluntarily and who are beneficiaries of the following State-funded assistance programs: Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U).

12.2.2.2. Individuals who are involuntarily detained in accordance with RCW 71.05 or RCW 71.34, and who are either eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program that would cover this hospitalization.

12.2.2.3. Individuals at least 22 years of age and under 65 years of age who are Medicaid-enrollees and are admitted to an Institute for Mental Diseases (IMD).

12.3. **Community Hospital Certification Process**: Adhere to the requirements set forth in the Community Psychiatric Inpatient Process as provided by MHD.

12.3.1. The Contractor shall have a Care Manager available 24 hours a day to respond to requests for inpatient certification. Certification decisions for psychiatric inpatient care must be made within twelve hours of the initial call.

12.4. **Psychiatric Inpatient Services: State Hospitals and CLIP**: The Contractor shall:

12.4.1. Maintain an In-Residence Census (IRC) in State Hospitals not to exceed the capacity funded by the legislature, and computed for the Contractor using the allocation outlined in WAC 388-865-0203 or any successor. The IRC will be adjusted the first day of the month following any legislatively mandated ward closure at Western State Hospital or Eastern State Hospital.

12.4.2. Ensure consumers are medically cleared, if possible prior to admission to a State psychiatric hospital.

12.4.3. Respond to State hospital census alerts by using best efforts to divert admissions and expedite discharges by utilizing alternative community resources and mental health services.

12.4.4. The Contractor or its designee shall monitor individuals discharged from inpatient hospitalizations on Less Restrictive Alternatives (LRA) under RCW 71.05.320 for individuals who meet medical necessity and the Access to Care Standards. The Contractor or designee shall offer covered mental health services to assist with compliance with LRA requirements.

12.4.5. The Contractor or its designee shall respond to requests for participation, implementation, and monitoring of individuals receiving services on Conditional Releases (CR) consistent with RCW 71.05.340. The Contractor or designee shall provide covered mental health services for individuals that meet medical necessity and the Access to Care Standards.

12.4.6. The Contractor shall ensure provision of services to individuals on a Conditional Release under RCW 10.77.150 for individuals that meet medically necessity and the Access to Care Standards.

12.4.7. For conditional releases under RCW 10.77, if the individual is placed on a transitional status in the RSN which holds the State psychiatric hospital, it is expected that the individual will transfer back to the RSN for the individual's county of residence once transitional care is complete. The Inter-RSN Transfer process described in the State hospital working agreement will be used when an individual is on conditional release or discharged to an area other than the RSN responsible for the individual's county of residence.

12.4.8. Develop a written working agreement with the State hospital in its service area within 90 days of the effective date of this Agreement. The agreements must include:

12.4.8.1. Specific roles and responsibilities of the parties related to transitions between the community and the hospital;

12.4.8.2. A process for the completion and processing of the Inter-RSN transfer request form for individuals requesting placement outside of the RSN of residence;

12.4.8.3. A process for resolution of disputes between RSNs and the assignment of individual costs when individuals are transferred between RSNs;

12.4.8.4. Collaborative discharge planning and coordination with cross-system partners; and

12.4.8.5. Identification and resolution of barriers which prevent discharge and systemic issues that create delays or prevent placements in the Contractor's service area.

12.5. **Children's Long-Term Inpatient Programs (CLIP)**

12.5.1. The Contractor shall coordinate with the Children's Long-term Inpatient Programs ("CLIP") Administration to develop CLIP resource management guidelines and admissions procedures. The Contractor shall enter into, and comply with, a written agreement with the CLIP Administration regarding resource management guidelines and admissions procedures.

12.6. **Inpatient Coordination of Care**

12.7. The Contractor must provide Rehabilitation Case Management: which includes a range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of an individual in the State mental health system.

12.7.1. Rehabilitation Case Management activities include assessment for discharge or admission to community mental health care, integrated mental health treatment planning, resource identification and linkage to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care.

12.7.2. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned re-admission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

12.8. The Contractor shall ensure that contact with the inpatient staff occurs within 3 working days of a voluntary or involuntary admission. The Contractor's liaison or CMHA must participate in treatment and discharge planning with the hospital staff.

12.8.1. The Contractor or its designee shall provide to the inpatient unit any available information regarding the individual's treatment history at the time of admission. The Contractor or its designee must provide all available information related to payment resources and coverage.

12.8.2. The Contractor's liaison or designated CMHA must participate in treatment and discharge planning with the inpatient treatment team. A CMHA must be designated prior to discharge for individuals and their families seeking community support services. The assigned CMHA must offer, at minimum, one follow – up service within 14 days from discharge.

12.8.3. The Contractor's liaison or designated CMHA must participate throughout the inpatient admission to assist with appropriate and timely discharge for all individuals regardless of diagnosis.

12.8.4. The Contractor's liaison or designated CMHA must coordinate with State hospital staff to develop appropriate community placement and treatment service plans.

12.8.5. The Contractor must designate a CMHA who has the primary responsibility to coordinate outpatient and residential services per section 2.4 to be provided to the individual based on medical necessity and available resources. The assigned CMHA must offer, at minimum, one follow – up service within 14 days from discharge.

12.9. **Medicaid Personal Care**: The Contractor or its designee must respond to requests for Medicaid Personal Care (MPC) from the DSHS Aging and Disability Services Administration (ADSA) within five working days of the request. The Contractor and the local ADSA office may mutually agree in writing to extend the five working day requirement. ADSA will use the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine service needed. The Contractor may not limit or restrict authorization for these services due to insufficient resources. Authorization decisions must be based on the following:

12.9.1. A review of the request to determine if the individual is currently authorized to receive services from the Prepaid Inpatient Health Plan in the Contractor's service area;

12.9.1.1. A verification that need for MPC services is based solely on the presence of a psychiatric disability; and

12.9.1.2. A review of the requested MPC services to determine if the individual's needs could be met through provision of other available RSN services.

12.9.2. If the Contractor denies authorization for MPC, the reason for the determination must be documented in the written response provided to ADSA.

12.9.2.1. When the Contractor denies authorization based on provision of other RSN services, a plan (e.g., Individual Service Plan) must be developed and implemented to meet the needs identified in the CARE assessment.

12.9.3. The Contractor must provide the following documentation to MHD on request:

12.9.3.1. The original ADSA referral and request for authorization;

12.9.3.2. Any information provided by ADSA including the CARE assessment;

12.9.3.3. A copy of the Contractor's determination and written response provided to ADSA; and

12.9.3.4. A copy of the plan developed and implemented to meet the individual's needs through provision of other available RSN services when the MPC request has been denied based on this determination.

12.10. **Residential Programs and Outpatient Mental Health Services**: When the Contractor has available resources, the Contractor shall provide Intake evaluations and all other services described in this section that are medically necessary to members of priority populations (RCW 71.24)." The Contractor must have policies and procedures that determine how the availability of resources for these services is determined, including how decisions are made to authorize intake evaluations or deny provision of services due to insufficient resources.

12.11. **Access to Services**: Once it is determined resources are available, access must be based on the following:

12.11.1. An intake evaluation consistent with WAC 388-865-0420 that is culturally and age relevant. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

12.11.1.1. An intake evaluation must be initiated within 10 working days of the request for mental health services. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, walk-in, or written request.

12.11.2. Authorization of intake shall be based on the Contractors policies and procedures. Authorization of other services shall be based on medical necessity, Access to Care Standards and the Contractors Level of Care Guidelines following an intake evaluation. A decision to authorize ongoing mental health services must occur within 14 calendar days from the date of request for mental health services unless the individual or the CMHA request an extension from the RSN.

12.11.2.1. An extension of up to 14 additional calendar days to make the authorization decision is possible upon request by the individual or the

CMHA. The Contractor must have a written policy and procedure to ensure consistent application of requests within the service area. The Contractor must monitor the use and pattern of extensions and apply corrective action where necessary.

12.11.3. The Contractor or its formal designee shall notify individuals of authorization decisions within 14 working days of the decision through written communication.

12.11.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested or described in the individual service plan must be determined by a Care Manager who is a Mental Health Professional with the appropriate clinical expertise to make that decision.

12.11.5. If the Contractor or their formal designee: a) denies a service authorization request; or b) authorizes a service in an amount, duration, or scope that is less than requested, the Contractor shall notify the requesting CMHA and the individual in writing within 14 working days of the decision.

12.11.6. Authorization for outpatient or residential services from the time of request must not take longer than 14 calendar days, unless the individual requests an extension.

12.12. Routine mental health services offered shall occur within 14 calendar days of a determination of an authorization. The time from request for services to first routine appointment must not exceed 28 calendar days unless the Contractor documents a reason for the delay.

12.13. **Residential Programs**: The full range of residential settings and programs must be available and provided based on the individual's needs, medical necessity and within available resources per the Contractor's policies and procedures. The Contractor must have contracts or memorandums of understanding to purchase a residential program outside of the Contractor's service area when an individual requires a level of residential support which is not available within the Contractor's service area. The full range of residential programs and settings include the following:

12.13.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers;

12.13.2. Supervised living such as residential programs developed to serve individuals diagnosed with a major mental illness in nursing homes, boarding homes or adult family homes; and

12.13.3. Supported housing services such as intensive services provided to maintain individuals in unlicensed individual or group home settings including transitional or permanent housing.

12.14. **Outpatient Mental Health Services**: Outpatient Service Modalities must be available and provided based on the individual's needs and medical necessity, within available resources per the Contractor's policies and procedures. The full range of outpatient mental health services are below:

12.14.1. Brief Intervention Treatment: Solution-focused and outcome-oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of an individual's current level of functioning or assistance with self/care or life skills training. An individual may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

12.14.2. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, schools, clubhouses, community centers). This service is available up to 5 hours per day, 5 days per week.

12.14.3. Family Treatment: Counseling provided for the direct benefit of an individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment is intended to benefit the client to obtain reintegration and recovery into the community. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their Individual Service Plan. This service is provided by or under the supervision of a mental health professional.

12.14.4. Group Treatment Services: Services provided to individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self-care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and/or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

12.14.5. High Intensity Treatment: Intensive service that is provided to individuals who require a multi-disciplinary treatment team in the community that is available during extended hours. Twenty-four hours per day, seven days per week, access is required if necessary for the individual. The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The team also has the ability to promptly assess, re-assess, and modify the individual service plan if the need arises. The team closely monitors symptoms and provides immediate feedback to the individual and to other team members. The team service intensity is individualized based upon continual assessment of need and adjustment to the individual service plan. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement. Services provided by the mental health professionals, mental health care providers and peer counselors are reportable components of this modality. The staff to consumer ratio for this service is no more than 1:15. *Although they participate, these team members are paid staff of other Departments.

12.14.6. Individual Treatment Services: A set of treatment services designed to help an individual attain goals as prescribed in their Individual Service Plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or

her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the individual. This service is provided by or under the supervision of a mental health professional.

12.14.7. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

12.14.8. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Individuals with low medication compliance history or newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional.

12.14.9. Mental Health Clubhouse: A service specifically contracted by the RSN to provide a consumer-directed program to individuals where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

12.14.9.1. Opportunities to work within the clubhouse. Such work contributes to the operation and enhancement of the clubhouse community;

12.14.9.2. Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness;

12.14.9.3. Assistance with employment opportunities, housing, transportation, education and benefits planning; and

12.14.9.4. Operate at least ten hours a week after 5:30pm Monday through Friday, or anytime on Saturday or Sunday, and

12.14.9.5.. Opportunities for socialization activities

12.14.10. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non-hospital) that offers a sub-acute psychiatric

management environment. Individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness and do treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to individual. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service differs from other services in the terms of location and duration.

12.14.11. Peer Support: Services provided by certified peer counselors to individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. These services may include self-help support groups, telephone support lines, drop-in centers, and engaging activities to locations where consumers are known to gather. Drop-in centers are required to maintain a log documenting identification of the consumers. This includes locations such as churches, parks, community centers, etc. Services are geared toward consumers with severe and persistent mental illness. Consumers actively participate in decision-making and the operation of the programmatic supports. Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plans which delineate specific goals that are flexible, tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, but treatment goals have not yet been achieved. Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams. Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

12.14.12. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

12.14.13. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home, etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional.

12.14.14. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist who considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral component of this service.

12.14.15. Supported Employment - Services will include:

12.14.15.1. An assessment of work history, skills, training, education, and personal career goals;

12.14.15.2. Information about how employment will affect income and benefits the consumer is receiving because of their disability;

12.14.15.3. Preparation skills such as resume development and interview skills;

12.14.15.4. Involvement with consumers served in creating and revising individualized job and career development plans that include;

12.14.15.4.1. Consumer strengths

12.14.15.4.2. Consumer abilities

12.14.15.4.3. Consumer preferences

12.14.15.4.4. Consumer's desired outcomes

12.14.15.5. Assistance in locating employment opportunities that is consistent with the consumer's strengths, abilities, preferences, and desired outcomes

12.14.15.6. Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.

12.14.15.7. Services are provided by or under the supervision of a mental health professional.

12.14.16. Therapeutic Psychoeducation: Informational and experiential services designed to aid individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the individual and are included in the Individual Service Plan.

12.14.16.1. The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc. Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional.

12.14.17. In addition to these services the Contractor may provide or purchase other outpatient services including, but not limited to, the following:

12.14.17.1. Assistance with application for entitlement programs;

12.14.17.2. Assistance with meeting the requirements of the Medically Needy spend down program; and

12.14.17.3. Services provided to Medicaid enrollees that are not included in the Medicaid State Plan or the 1915(b) Waiver.

12.15. The Contractor shall notify DSHS in writing of any change in capacity that results in the Contractor being unable to provide any of the services in this agreement. Events that may affect capacity include: loss of a CMHA, decrease in the number or frequency of a required service, or any change that results in the Contractor being unable to provide medically necessary services. DSHS must approve any change that results in reduced capacity for more than 30 days.

13. COMMUNITY COORDINATION

13.1. **Tribal Relationships**: The Contractor and its subcontractors must recognize the unique social/legal status of Indian Nations as required by both the Supremacy

and the Indian Commerce Clauses of the United States Constitution; federal treaties; executive orders; Indian Citizens Act of 1924; and State and federal court decisions; or any Memorandum of Agreement or Understanding signed by the State of Washington and a federally recognized tribe of recognized organization.

13.2. The Contractor shall develop a written plan in a format provided by MHD as Exhibit B which addresses delivery of medically necessary mental health services to Indian Nations within the Contractor's service area. The plan must be developed in collaboration with each Indian Nation in the Contractor's service area. The plan must be submitted to MHD within 90 days of the execution of this contract unless an extension has been granted by the MHD. The MHD will review and must approve the submitted plan. Provide documentation if the tribal authority declines to participate. The Contractor shall use the attached RSN/ Tribal Collaboration Planning Checklist as Exhibit B and the plan must contain:

13.2.1. Identification of Tribal Administration and relevant provider contacts for each Indian Nation in the Contractor's service area;

13.2.2. A description of completed and planned collaboration activities with each Indian Nation;

13.2.3. A list of any culturally-sensitive issues or culturally-specific needs identified during consultation;

13.2.4. Identification and process for the provision of culturally-appropriate, sensitive, and relevant medically necessary mental health services for eligible Tribal MH clients needing services through the RSN;

13.2.5. A description of any completed or planned Tribal Relations training to be provided to the RSN Administration and staff by the Contractor; and

13.2.6. Collaborative development of performance indicators which will be used to measure and evaluate the implementation and effectiveness of the RSN/ Tribal Collaboration plan.

13.3. **Disaster Response**

13.3.1. The Contractor must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by MHD. The Contractor must:

13.3.1.1. Attend MHD-sponsored training regarding the role of the public mental health system in disaster preparedness and response;

13.3.1.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration;

13.3.1.3. Provide Disaster Outreach in Contractor's service area in the event of a disaster/emergency; "Disaster Outreach" means contacting individuals in their place of residence or in non-traditional settings for the purpose of assessing their mental health and social functioning following a disaster or increasing the utilization of human services and resources.

13.3.1.4. There are two basic approaches to outreach: mobile (going to person to person and community settings (e.g. temporary shelters, disaster assistance sites, disaster information forums). The Outreach Process must include the following:

13.3.1.4.1. locating persons in need of disaster relief services;

13.3.1.4.2. assessing their needs;

13.3.1.4.3. engaging or linking persons to an appropriate level of support or disaster relief services; and,

13.3.1.4.4. providing follow-up mental health services when clinically indicated.

13.3.1.5. Disaster outreach can be performed by trained volunteers, peers and/or persons hired under a federal Crisis Counseling Grant. These persons should be trained in disaster crisis outreach which is different than traditional mental health crisis intervention.

13.3.1.6. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs;

13.3.1.7. Provide the name and contact information to MHD for person(s) coordinating the RSN disaster/emergency preparedness and response upon request;

13.3.1.8. Provide information and preliminary disaster response plans to MHD within 7 days following a disaster/emergency or upon request; and

13.3.1.9. Partner in disaster preparedness and response activities with MHD and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:

13.3.1.9.1. Participation when requested in local and regional disaster planning and preparedness activities; and

13.3.1.9.2. Coordination of disaster outreach activities following an event.

13.4. **Jail Coordination Services**

13.4.1. The Contractor shall coordinate with local law enforcement and jail personnel including the development and execution of Memorandum of Understandings with local county and city jails in the Contractors' service area which detail a referral process for individuals who are incarcerated who have been diagnosed with a mental illness or identified as in need of mental health services.

13.4.2. The Contractor shall identify and provide transition services to individuals with mental illness to expedite and facilitate the individual' return to the community.

13.4.3. The Contractor shall accept referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in RCW 71.24. The Contractor shall conduct mental health intake assessments for these individuals and when appropriate provide transition services prior to their release from jail.

13.4.4. The Contractor shall develop and execute a Memorandum of Understanding with local community service offices (CSO) for expedited application or reinstatement of medical assistance for individuals in jails, prisons, or IMDs. The Contractor shall assist individuals with mental illness in completing and submitting applications for medical assistance to the local CSO prior to release from jail.

13.4.5. The Contractor shall provide a quarterly report in a format provided by the MHD on services provided with the funding designated in the Payment section for this program.

13.4.6. Jail Coordination Services Report Schedule.

Service Period	Due Date
September –November 2006	December 5, 2006
December 2006– February 2007	March 10, 2007
March – June 2007	July 10, 2007

13.5. The Contractor may use the Jail Coordination Services funds provided to facilitate the following activities if there are sufficient resources:

13.5.1. Daily cross-reference between new bookings and the RSN data base to identify newly booked, persons known to the RSN;

13.5.2. Development of individual alternative service plans (alternative to the jail) for submission to the courts – if receptive;

13.5.3. Pre-release transition planning (e.g. assessments, mental health services, co-occurring services, and housing);

13.5.4. Intensive post-release outreach to ensure individuals follow up with CSO and appointments for mental health and other services (e.g. substance abuse);

13.5.5. Inter-local agreements with juvenile detentions facilities;

13.5.6. Training to local law enforcement and jail services personnel; and

13.5.7. Provision of some direct mental health services to individuals who are in small jails which have no mental health staff.

14. **REMEDIAL ACTIONS**:

14.1. MHD may initiate remedial action if it is determined that any of the following situations exist:

14.1.1. A problem exists that negatively impacts individuals receiving services.

14.1.2. The Contractor has failed to perform any of the mental health services required in this Agreement.

14.1.3. The Contractor has failed to develop, produce, and/or deliver to MHD any of the statements, reports, data, data corrections, accountings, claims, and/or documentation described herein, in compliance with all the provisions of this Agreement.

14.1.4. The Contractor has failed to perform any administrative function required under this Agreement. For the purposes of this section, “administrative function” is defined as any obligation other than the actual provision of mental health services.

14.1.5. The Contractor has failed to implement corrective action required by the State and within MHD prescribed timeframes.

14.2. MHD may impose any of the following remedial actions:

14.2.1. Require the Contractor to develop and execute a corrective action plan. Corrective action plans developed by the Contractor must be submitted for approval to MHD within 30 calendar days of notification. Corrective action plans may require modification of any policies or procedures by the Contractor relating to the fulfillment of its obligations pursuant to this Agreement. MHD may extend or reduce the time allowed for corrective action depending upon the nature of the situation.

14.2.1.1. Corrective action plans must include:

14.2.1.1.1. A brief description of the situation requiring corrective action;

14.2.1.1.2. The specific actions to be taken to remedy the situation;

14.2.1.1.3. A timetable for completion of the actions; and

14.2.1.1.4. Identification of individuals responsible for implementation of the plan;

14.2.1.2. Corrective action plans are subject to approval by MHD, which may:

14.2.1.2.1. Accept the plan as submitted;

14.2.1.2.2. Accept the plan with specified modifications;

14.2.1.2.3. Request a modified plan; or

14.2.1.2.4. Reject the plan.

14.2.2. Withhold up to five percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. MHD, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

14.2.3. Increase withholdings identified above by up to an additional three percent for each successive month during which the remedial situation has not been resolved.

14.2.4. Deny any incentive payment to which the Contractor might otherwise have been entitled under this Agreement or any other arrangement by which MHD provides incentives.

14.2.5. Terminate for Default as described in the General Terms and Conditions.

15. GENERAL TERMS AND CONDITIONS

15.1. **Assignment.** The Contractor shall not assign this Agreement or Program Agreement to a third party without the prior written consent of DSHS.

15.2. **Amendment**. This Agreement may only be modified by a written amendment signed by both parties. Only personnel authorized to bind each of the parties may sign an amendment.

15.3. **Billing Limitations.** Unless otherwise specified in this Agreement, DSHS shall not pay any claims for services submitted more than twelve (12) months after the calendar month in which the services were performed.

15.4. **Compliance with Applicable Law**. At all times during the term of this Contract, the Contractor shall comply with all applicable federal, State, and local laws and regulations, including but not limited to, nondiscrimination laws and regulations.

15.5. **Confidentiality.** In addition to any other provisions in this Agreement regarding confidentiality, the parties shall use Personal Information and other information gained by reason of this Agreement only for the purpose of this Agreement. DSHS and the Contractor shall not disclose, transfer, or sell any such information to any other party, except as provided by law or, in the case of Personal Information, without the prior written consent of the person to whom the Personal Information pertains. The parties shall maintain the confidentiality of all Personal Information and other information gained by reason of this Agreement and shall return or certify the destruction of such information if requested in writing by the party to this Agreement that provided the information.

15.6. **Debarment Certification.** The Contractor, by signature to this Agreement certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this Agreement by any Federal department or agency. The Contractor also agrees to include the above requirement into any subcontracts entered into, resulting directly from the Contractor's duty to provide services under this Agreement.

15.7. **Entire Agreement.** This Agreement, including all documents attached to or incorporated by reference, contains all the terms and conditions agreed upon by the parties. No other understandings or representations, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or bind the parties.

15.8. **Governing Law and Venue.** This contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior Court for Thurston County. In the event that an action is properly brought in, or removed to, U.S. District Court, venue shall be in the Western District of Washington.

15.9. **Independent Contractor.** The parties intend that an independent contractor relationship will be created by this contract. The Contractor and his or her employees or agents performing under this contract are not employees or agents of the Department. The Contractor, his or her employees, or agents performing under this contract will not hold himself/herself out as, nor claim to be, an officer or employee of the Department by reason hereof, nor will the Contractor, his or her employees, or agent make any claim of right, privilege or benefit that would accrue to such employee.

15.10. **Inspection.** During the term of this Agreement, and for one (1) year following termination or expiration of this Agreement, the Contractor shall provide reasonable access to the Contractor's and subcontractor's place of business, Contractor records, and client records, to DSHS and to any authorized agent of the State of Washington or federal government in order to monitor, audit, and evaluate the Contractor's performance and compliance with applicable laws, regulations, and this Agreement.

15.11. **Order of Precedence.** In the event of any inconsistency or conflict between the General Terms and Conditions and the Special Terms and Conditions of this

Agreement or any Program Agreement, the inconsistency or conflict shall be resolved by giving precedence to these General Terms and Conditions

15.12. **Severability.** If any term or condition of this Contract is held invalid by any court, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

15.13. **Survivability.** The terms and conditions contained in this Agreement which by their sense and context, are intended to survive the expiration of this Agreement shall so survive. Surviving terms include, but are not limited to: Confidentiality, Disputes, Inspection, Maintenance of Records, Mutual Indemnification and Hold Harmless, Ownership of Material, Termination for Default, Termination Procedure, and Treatment of Assets Purchased by the RSN, and Treatment of Property.

15.14. **Termination Due to Change in Funding:** If the funds upon which DSHS relied to establish this Agreement are withdrawn, reduced, or limited, or if additional or modified conditions are placed on such funding, DSHS may terminate this Agreement by providing at least five (5) business days' written notice to the Contractor. The termination shall be effective on the date specified in the notice of termination.

15.15. **Waiver.** Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the DSHS Chief Administrative Officer or designee has the authority to waive any term or condition of this Contract on behalf of DSHS.

16. SPECIAL TERMS AND CONDITIONS

16.1. **Advisory Board**: The Contractor shall maintain an advisory board that is broadly representative of the demographic character of the region which shall include, but not be limited to, representatives of consumers and families, and law enforcement. Composition and length of terms of board members may differ between regional support networks. Membership shall be comprised of at least 51% consumers or consumer family members as defined in WAC 388-865-0222. Composition of the advisory board and the length of terms must be submitted to MHD by January 30, 2007 for approval.

16.2. **Compliance with Applicable Law**. At all times during the term of this Agreement, the Contractor shall comply with all applicable federal, State, and local laws, regulations, and rules, including but not limited to, nondiscrimination laws and regulations, and the following, whether or not a specific citation is identified in various sections of this Agreement:

16.2.1. Title XIX and Title XXI of the Social Security Act and Title 42 of the Code of Federal Regulations.

16.2.2. All applicable Office of Insurance Commissioner's (OIC) statutes and regulations.

16.2.3. All local, State, and federal professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Agreement.

16.2.4. All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 USC §1857(h)), Section 508 of the Clean Water Act (33 USC §1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to DSHS, Department of Health and Human Service (DHHS), and the EPA.

16.2.5. Any applicable mandatory standards and policies relating to energy efficiency which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act.

16.2.6. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

16.2.7. Those specified in Title 18 RCW for professional licensing.

16.2.8. Reporting of abuse as required by RCW 26.44.030.

16.2.9. Industrial insurance coverage as required by Title 51 RCW.

16.2.10. Any other requirements associated with the receipt of federal funds.

16.2.11. Any provision of this Agreement which conflicts with State and federal statutes, or regulations, or Centers for Medicare and Medicaid Services (CMS) policy guidance is hereby amended to conform to the provisions of State and federal law and regulations.

16.3. **Confidentiality of Personal Information**

16.3.1. The Contractor shall protect all Personal Information, records, and data from unauthorized disclosure in accordance with 42 CFR §§431.300 through 431.307, RCW 70.02, RCW 71.05, RCW 71.34, and for individuals receiving substance abuse services, in accordance with 42 CFR Part 2 and RCW 70.96A. The Contractor shall have a process in place to ensure that all components of its provider network and system understand and comply with confidentiality requirements for publicly funded mental health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Agreement and the State Medicaid Plan. Such purposes include, but are not limited to:

16.3.1.1. Establishing eligibility;

16.3.1.2. Determining the amount of medical assistance;

16.3.1.3. Providing services for recipients;

16.3.1.4. Conducting or assisting in investigation, prosecution, or civil or criminal proceedings related to the administration of the State Medicaid Plan;

16.3.1.5. Assuring compliance with federal and State laws and regulations, and with terms and requirements of the Agreement; and

16.3.1.6. Improving quality.

16.3.2. The Contractor shall comply with all confidentiality requirements of the Health Insurance Portability and Accountability Act (42 CFR §§ 160 -164).

16.4. **Contractor Certification Regarding Ethics.** By signing this Agreement, the Contractor, whether county-based or not, certifies that the Contractor is in compliance with the standards set forth in RCW 42.23, and shall comply with these standards throughout the term of this Agreement.

16.5. **Declaration That Individuals Service Under the Medicaid and Other Mental Health Programs Are Not Third-Party Beneficiaries Under this Agreement.** Although DSHS and the Contractor mutually recognize that services under this Agreement will be provided by the Contractor to individuals receiving services under the Medicaid program, and RCW 71.05, RCW 71.24, and RCW 71.34, it is not the intention of either DSHS or the Contractor that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Agreement.

16.6. **Disputes**. When a dispute arises over an issue concerning the terms of this Agreement, the parties agree to the following process to address the dispute.

16.6.1. The Contractor and DSHS shall attempt to resolve the dispute through informal means between the Contractor and DSHS Contact listed on page one (1) of this Agreement.

16.6.2. If the Contractor is not satisfied with the outcome, the Contractor may submit the disputed issue, in writing, for review, within ten (10) working days of the postmark of the notice from DSHS, to: Chief, Mental Health Services, Mental Health Division, P.O. Box 45320, Olympia, WA 98504-5320.

16.6.3. The Chief, Mental Health Services, may request additional information from the DSHS Contact and/or the Contractor. The Chief shall issue a written review decision to the Contractor within thirty (30) calendar days of receipt of all information relevant to the issue. The review decision will be provided to the Contractor.

16.6.4. When the Contractor disagrees with the written review decision of the Chief, the Contractor may request independent mediation of the dispute. The

request for mediation must be submitted to the MHD Director, in writing within ten (10) working days of the Contractor's receipt of the Chief's review decision. The Contractor and DSHS shall mutually agree on the selection of the independent mediator and shall bear all cost associated with mediation equally. The results of mediation shall not be binding on either party.

16.6.5. Both parties agree to make their best efforts to resolve disputes arising from this Agreement and agree that the dispute resolution process described herein shall precede any court action. This dispute resolution process is the sole administrative remedy available under this Agreement.

16.7. **Duplicative Reports and Deliverables.** If this Agreement requires a report or other deliverable that contains information that is duplicative or overlaps a requirement of another Agreement between the parties the Contractor may provide one report or deliverable that contains the information required by both Agreements.

16.8. **Fraud and Abuse.** The Contractor shall do the following to guard against fraud and abuse:

16.8.1. Create and maintain a mandatory compliance plan;

16.8.2. Develop written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

16.8.3. Designate a compliance officer and a compliance committee that is accountable to senior management;

16.8.4. Provide effective ongoing training and education for the compliance officer, staff of the PIHP, and selected staff of the CMHAs;

16.8.5. Facilitate effective communication between the compliance officer, the PIHP employees, and the Contractor's network of CMHAs;

16.8.6. Enforce standards through well-publicized disciplinary guidelines;

16.8.7. Conduct internal monitoring and auditing;

16.8.8. Respond promptly to detected offenses and develop corrective action initiatives; and

16.8.9. Report fraud and/or abuse information to MHD as soon as it is discovered including the source of the complaint, the involved CMHA, nature of fraud or abuse complaint, approximate dollars involved, and the legal and administrative disposition of the case.

16.9. **Information Requests**: The Contractor shall maintain information necessary to promptly respond to written requests by the MHD Director, an Office Chief or their designee. The Contractor shall submit information detailing the amount spent throughout their service area on specific items upon request by MHD Director, an Office Chief or their designee.

16.10. **Insurance.** The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains insurance. The Contractor shall pay for losses for which it is found liable. The Contractor shall provide a certificate of insurance at the time of renewal or at least annually.

16.11. **Indemnification and Hold Harmless**. The Contractor shall be responsible for and shall indemnify and hold DSHS harmless from all claims or damages resulting from negligent acts or omissions of the Contractor and any subcontractor.

16.12. **Lobby Activities Prohibited.** Federal Funds must not be used for Lobbying activities.

16.13. **Maintenance of Records**. During the term of this Agreement and for six (6) years following termination or expiration of this Agreement, or if any audit, claim, litigation, or other legal action involving the records is started before expiration of the six year period, the records shall be maintained until completion and resolution of all issues arising there from or until the end of the six year period, whichever is later.

16.13.1. The Contractor shall maintain records sufficient to:

16.13.1.1. Maintain the content of all medical records in a manner consistent with utilization control requirements of 42 CFR §456, 42 CFR §434.34 (a), 42 CFR §456.111, and 42 CFR §456.211;

16.13.1.2. Document performance of all acts required by law, regulation, or this Agreement;

16.13.1.3. Substantiate the Contractor's statement of its organization's structure, tax status, capabilities, and performance; and

16.13.1.4. Demonstrate the accounting procedures, practices, and records that sufficiently and properly document the Contractor's invoices to DSHS and all expenditures made by the Contractor to perform as required by this Agreement.

16.13.2. The Contractor and its subcontractors shall cooperate in all reviews, including but not limited to surveys, and research conducted by DSHS or other Washington State Departments.

16.13.3. Evaluations under this Agreement shall be done by inspection or other means to measure quality, appropriateness, and timeliness of services, and to determine whether the Contractor and its subcontractors are providing service to individuals in accordance with the requirements set forth in this Agreement and applicable State and federal regulations as existing or hereafter amended.

16.13.4. DSHS shall maintain books, records, documents, and other materials relevant to this Agreement which sufficiently and properly reflect all payments made, including the Department's rate setting activities related to the Contractor, or other actions taken in regard to the Contractor's performance of the services described herein.

16.14. **Overpayments**. If it is determined by DSHS, or during the course of a required audit, that the Contractor has been paid unallowable costs under this Agreement, DSHS may require the Contractor to reimburse DSHS in accordance with OMB Circular A-87.

16.15. **Ownership of Material**. Material created by the Contractor and paid for by DSHS as a part of this Agreement shall be owned by DSHS and shall be "work made for hire" as defined by the US Copyright Act, 17 USC, Section 101. This material includes, but is not limited to: books; computer programs; documents; films; pamphlets; reports; sound reproductions; studies; surveys; tapes; and/or training materials. Material which the Contractor uses to perform this Agreement, but which is not created for or paid for by DSHS is owned by the Contractor; however, DSHS shall have a perpetual license to use this material for DSHS internal purposes at no charge to DSHS.

16.16. **Subcontracting**. The Contractor may subcontract services to be provided under this Agreement. The Contractor shall be responsible for the acts and omissions of any subcontractors.

16.16.1. The Contractor shall not subcontract with an individual provider or an entity with an individual who is an officer, director, agent, or manager, or who owns or has a controlling interest in the entity, and who has been convicted of crimes as specified in 42 USC §1320a.

16.17. **Subrecipients.** If the Contractor is a subrecipient of federal awards as defined by Office of Management and Budget (OMB) Circular A-133 and this Agreement, the Contractor shall:

16.17.1. Maintain records that identify, in its accounts, all federal awards received and expended and the federal programs under which they were received, by Catalog of Federal Domestic Assistance (CFDA) title and number, award number and year, name of the federal agency, and name of the pass-through entity;

16.17.2. Maintain internal controls that provide reasonable assurance that the Contractor is managing federal awards in compliance with laws, regulations, and provisions of contracts or grant agreements that could have a material effect on each of its federal programs;

16.17.3. Prepare appropriate financial statements, including a schedule of expenditures of federal awards;

16.17.4. Incorporate OMB Circular A-133 audit requirements into all agreements between the Contractor and its subcontractors who are subrecipients;

16.17.5. Comply with any future amendments to OMB Circular A-133 and any successor or replacement Circular or regulation;

16.17.6. Comply with the applicable requirements of OMB Circular A-87 and any future amendments to OMB Circular A-87, and any successor or replacement Circular or regulation; and

16.17.7. Comply with the Omnibus Crime Control and Safe streets Act of 1968, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990, Title IX of the Education Amendments of 1972, The Age Discrimination Act of 1975, and The Department of Justice Non-Discrimination Regulations, 28 C.F.R. Part 42, Subparts C.D.E. and G, and 28 C.F.R. Part 35 and 39. (See www.ojp.usdoj/gov/ocr for additional information and access to the aforementioned Federal laws and regulations.)

16.18. **Single Audit Act Compliance.** If the Contractor is a subrecipient and expends $500,000 or more in federal awards from any and/or all sources in any fiscal year, the Contractor shall procure and pay for a single audit or a program-specific audit for that fiscal year. Upon completion of each audit, the Contractor shall:

16.18.1. Submit to the DSHS contact person, listed on the first page of this Agreement, the data collection form and reporting package specified in OMB Circular A-133, reports required by the program-specific audit guide (if applicable), and a copy of any management letters issued by the auditor; For purposes of “subrecipient” status under the rules of OMB Circular A-133 205(i) Medicaid payments to a subrecipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part of the rule unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

16.18.2. Follow-up and develop corrective action for all audit findings; in accordance with OMB Circular A-133, prepare a “Summary Schedule of Prior Audit Findings.”

16.19. **Termination for Convenience**. DSHS Contracts Administrator may terminate this Agreement, in whole or in part, when it is in the best interest of DSHS by giving the Contractor at least 90 calendar days' written notification by certified mail. The Contractor may terminate this Agreement for convenience by giving DSHS at least 90 calendar days' written notification receipt by certified mail addressed to: Mental Health Division, PO Box 45320, Olympia, Washington 98504-5320

16.19.1. The effective date of the termination shall be the last day of the calendar month in which the ninetieth day occurs.

16.20. **Termination by DSHS for Default**

16.20.1. The CCS Contracts Administrator may terminate this Agreement for default, in whole or in part, by written notice to the Contractor, if DSHS has a reasonable basis to believe that the Contractor has:

16.20.1.1. Failed to meet or maintain any requirement for contracting with DSHS.

16.20.1.2. Failed to perform under any provision of this Agreement;

16.20.1.3. Performed any of the Contractor's obligations under this Agreement in a manner that comprised the health or safety of any individual with whom the Contractor had contact;

16.20.1.4. Violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement, including those pertaining to health and safety; or

16.20.1.5. Otherwise breached any provision or condition of this Agreement.

16.20.2. Before the CCS Contracts Administrator may terminate this Agreement for default, DSHS shall provide the Contractor with written notice of the Contractor's noncompliance with this Agreement and provide the Contractor a reasonable opportunity to correct the Contractor's noncompliance. If the Contractor does not correct the Contractor's noncompliance within the period of time specified in the written notice of noncompliance, the CCS Contracts Administrator may then terminate this Agreement. The CCS Contracts Administrator, however, may terminate this Agreement for default without such written notice and without opportunity for correction if DSHS has a reasonable basis to believe that an individual's health or safety is in jeopardy or if the Contractor has violated any law, regulation, rule, or ordinance applicable to the services provided under this Agreement.

16.21. **Termination Procedure**. The following provisions shall survive and be binding on the parties in the event this Agreement is terminated:

16.21.1. The Contractor shall cease to perform any services required by this Agreement as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of individuals, distribution of property, and termination of services. Each party shall be responsible only for its performance in accordance with the terms of this Agreement, rendered prior to the effect date of termination. The Contractor shall assist in the orderly transfer/transition of the individuals served under this Agreement. The Contractor shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims

16.21.2. The Contractor shall immediately deliver to the DSHS contact person (or to his or her successor) listed on the first page of this Agreement, all DSHS assets (property) in the Contractor's possession, including any material created under this Agreement. The Contractor grants DSHS the right to enter upon the Contractor's premises for the sole purpose of recovering any DSHS property that the Contractor fails to return within ten (10) working days of termination of this Agreement. Upon failure to return DSHS property within ten (10) working days of termination of this Agreement, the Contractor shall be charged with all reasonable costs of recovery, including transportation and attorney's fees. The Contractor shall protect and preserve any property of DSHS that is in the possession of the Contractor pending return to DSHS.

16.21.3. DSHS shall be liable for and shall pay for only those services authorized and provided through the date of termination. DSHS may pay an amount agreed by the parties for partially completed work and services, if work products are useful to or usable by DSHS.

16.21.4. If the CCS Contracts Administrator terminates this Agreement for default, DSHS may withhold a sum from the final payment to the Contractor that DSHS determines necessary to protect DSHS against loss or additional liability. DSHS shall be entitled to all remedies available at law, in equity, or under this Agreement, including consequential damages, incidental damages, legal fees, and costs. If it is later determined that the Contractor was not in default, the Contractor shall be entitled to all remedies available at law, in equity, or under this Agreement, including consequential damages, incidental damages, legal fees, and costs.

16.21.5. The DSHS Secretary may direct assignment of the Contractor's rights to and interest in any subcontract or orders placed to DSHS. DSHS may terminate any subcontract or orders and settle or pay any or all claims arising out of the termination of such orders and subcontracts.

16.22. **Treatment of Individual's Property**. Unless otherwise provided in this Agreement, the Contractor shall ensure that any adult individual receiving services from the Contractor under this Agreement has unrestricted access to the individual's personal property. The Contractor shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. The

Contractor shall provide individuals under age eighteen (18) with reasonable access to their personal property that is appropriate to the individual's age, development, and needs. Upon termination of this Agreement, the Contractor shall immediately release to the individual and/or the individual's guardian or custodian all of the individual's personal property.

16.23. **Treatment of Property**. Title to all property purchased or furnished by DSHS for use by the Contractor during the term of this Agreement shall remain with DSHS. Title to all property purchased or furnished by the Contractor for which the Contractor is entitled to reimbursement by DSHS under this Agreement shall pass to and vest in DSHS. The Contractor shall protect, maintain, and insure all DSHS property in its possession against loss or damage and shall return DSHS property to DSHS upon this Agreement's termination or expiration.

16.23.1. Except as provided in this Agreement, title to all property purchased or furnished by the Contractor is vested in the Contractor and DSHS waives all claim of ownership to such property.